TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GRAPEVINE SURGICARE

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-17-2731-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 15, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to Texas Workers' Compensation Rule 134.402, 'Implantable devices are reimbursed at the providers cost plus 10% up to $1,000.00 per item or $2,000.00 per case.' In this case our implants cost more than was paid on the claim."

Amount in Dispute: $1766.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The drill bit, ultrabutton, and rap-pac are not implantable but devices used to help deliver the implants to the correct anatomical placement. Thus, no payment is due. . . . Biologicals are not paid as implantable per Ch. 134 DWC rule and Medicare. The Posterior Tibialis tendon is consider a biological. Thus no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 10, 2017	Implantable items related to ambulatory surgery.	$1766.73	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the medical fee guideline for ambulatory surgery centers.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 725 – APPROVED NON-NETWORK PROVIDER FOR TEXAS STAR NETWORK CLAIMANT PER RULE 1305.153(C).
   - 764 – REIMBURSED PER ASC FG AT 153%. SEPARATE REIMBURSEMENT FOR IMPLANTABLES (INCLUDING SINGED CERTIFICATION) WAS REQUESTED PER RULE 134.402(G).
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
   - 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 723 – SUPPLEMENTAL REIMBURSEMENT ALLOWED AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824.
   - 897 – SEPARATE REIMBURSEMENT FOR IMPLANTABLES MADE IN ACCORDANCE WITH DWC RULE CHAPTER 134; SUBCHAPTER (E) HEALTH FACILITY FEES.

Issues

1. Does the claim lack information that is needed for adjudication or to support the items as billed?
2. Did the requestor support that additional reimbursement is due?

Findings

1. The insurance carrier denied disputed implantable items, in part, with claim adjustment reason codes:
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.

   The disputed implantable items were billed using the correct form, per rule §133.10 regarding required billing forms and formats; however, Rule §133.10(f)(1)(W) states that "supplemental information (shaded portion of CMS-1500/fields 24d - 24h) is required when the provider is requesting separate reimbursement for surgically implanted devices or when additional information is necessary to adjudicate payment for the related service line."

   The health care provider billed HCPCS code L8699, 1 unit, indicating an unspecified prosthetic implant. The requestor submitted invoices for multiple alleged implantable items that were not included on the bill itself, either by HCPCS code or by number of units.

   Both Medicare payment policies and division rules require the provider to provide supplemental information describing the item or procedure when such unspecified codes (typically ending in 99) are billed. In this case, there is no such information on the bill to enable identification of what the implantable items are for which separate reimbursement is requested.

   Additionally, Rule §133.20(c) requires that "a health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."

   Moreover, Rule §134.402(d) requires that for coding, billing, and reporting, of covered facility services, "Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs."

Review of the submitted documentation finds that the medical bill did not include appropriate codes or units indicating the implantable items for which separate reimbursement was sought sufficient to meet the requirements of division rules and Medicare payment policies.

Such information might be gleaned from the supporting documentation, but the requestor is asking for reimbursement of more than one item, yet has only billed for one unit on the claim.

Review of the operative report is inconclusive as to what items were implanted in the injured employee — other than an 8x3 mm screw. It is not clear, though, that the invoice purporting to be for that screw matches the actual item implanted in the patient — as the invoice indicates an 8x30 mm screw (as opposed to the item documented in the Operative Report, an 8x3 mm screw).

Additionally, the invoice for the screw states "package price" without indicating, at least in any obvious fashion, the quantity of screws contained in the package. It is therefore undetermined whether the invoice price represents the price of a single screw or an indefinite number of screws — if it indeed matches the screw that was implanted in the patient, which is also unclear.

Based on the preponderance of evidence submitted for review to MFDR, the requestor has failed to submit adequate documentation to support the items as billed. The carrier's above denial reasons are supported.

2. This dispute regards reimbursement for the facility services of an ambulatory surgical center subject to 28 Texas Administrative Code §134.402(f), which requires the calculation used to establish the maximum allowable reimbursement (MAR) shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register based on the payment amount listed in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES applicable to the date of service, with minimal modifications as specified by the rule.

   Per Rule §134.402(b)(5), "Implantable" means an object or device that is surgically: (A) implanted, (B) embedded, (C) inserted, (D) or otherwise applied, and (E) related equipment necessary to operate, program, and recharge the implantable.

   Rule §133.307(c)(2)(N) requires the requestor to submit a position statement that shall include:

   (i) the requestor's reasoning for why the disputed fees should be paid or refunded,
   (ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and
   (iii) how the submitted documentation supports the requestor's position for each disputed fee issue;

   Although the requestor did include a position statement, the position statement did not include enough information to support the requestor's argument for additional payment. Specifically, the position statement did not explain how the submitted documentation supports the requestor's position for each disputed fee issue or how the disputed implantable items meet the definition of implantables in the division's rules.

   The respondent argues that "The drill bit, ultrabutton, and rap-pac are not implantable but devices used to help deliver the implants to the correct anatomical placement. Thus, no payment is due." The preponderance of the submitted evidence weighs in favor of the respondent on this point. As will be detailed further below, the respondent is seeking separate reimbursement for supplies in general that are included in the payment for the surgical package, and which are not specifically "implantables." The requestor's documentation fails to support the items as billed or that the items are "implantables" according to the definition in the rule.

   With regard to the drill bit, it is not clear why this equipment is not reusable by the hospital and should be billed to the injured employee's insurance carrier. Facilities are expected to have on-hand the ordinary equipment necessary to provide health care in accordance with their licensure requirements. Regardless, per Medicare payment policies, reimbursement for certain equipment and non-durable supplies attendant to the surgery is included in the payment for the surgical package; such items are not separately paid. The medical documentation does not support that the drill bit was implanted in the patient. The health care provider has not supported that this is an "implantable" eligible for separate reimbursement in accordance with the definition of the rule.

With regard to the ultrabutton, the insurance carrier asserts this is not an implantable, but rather a device for delivering an implantable to an anatomic site. Review of the operative report is inconclusive. It details the use of an "ultrabutton reamer"; a reamer is tool for reaming—not an implantable. The report also details a graft "applied to Smith & Nephew ultrabutton." The documentation supports this item was used to seat the graft at the tibial site. The documentation does not say whether this item was removed or left inside the patient after surgery. The documentation supports the graft was fixated with a biocomposite screw — but does not say whether the ultrabutton (or any part of that device) remained inside the patient to also aid in fixing the graft.

The submitted documentation is inconclusive as to whether the ultrabutton meets the definition of an implantable. The division thus finds the requestor has failed to provide adequate documentation to describe the disputed "ultrabutton" or support the service as billed. Furthermore, the requestor has not supported that the ultrabutton meets the definition of an implantable in accordance with the rule. Based on the preponderance of evidence, the division concludes the requestor has failed to support that additional reimbursement is due for the disputed ultrabutton.

With regard to the "rap-pac," the documentation also fails to describe or support this item as billed. It is unclear from the documentation what a "rap-pac" is. A cursory internet search finds that a "rap-pac" is either a disposable arthroscopic procedure kit, or a collection of 80's and 90's old school Hip-Hop music singles. The former is a surgical supply kit containing sterile surgical and endoscopic instruments, dressings and necessary materials for performing arthroscopy. Absent more extensive documentation, the division finds the later does not meet the definition of a medical benefit under Labor Code Section 408.021(a). The medical documentation does not support that either was implanted in the injured employee. As stated above, the facility is expected to have on-hand ordinary equipment and supplies reasonably required to perform the health care it delivers. Per Medicare payment policies, reimbursement for certain equipment and non-durable supplies attendant to the surgery is included in the payment for the surgical package; such items are not separately paid.

With regard to the tibial graft, the insurance carrier asserts that it is a biological, and that biologicals are not paid as implantable per Chapter 134 of division rules or Medicare payment policies. This argument is not supported. Division rules supersede Medicare payment policies where expressly stated, or as modified by division rules. The division rule regarding separate reimbursement of implantables is one such instance where Medicare payment polices are superseded (Medicare does not separately pay for implantables at all).

The division's definition does not *automatically* excluded biologicals from separate reimbursement as implantables, though the division *has* excluded certain biologicals (such as liquids and autografts) in prior medical fee dispute decisions—that are not relevant in this dispute.

Even so, the medical bill does not include a separate line item describing the graft. As stated above, the medical documentation does not support the item as billed in accordance with division rules and Medicare payment polices. For that reason, additional reimbursement is not recommended.

Lastly, of all the items, the screw used to fixate the graft is clearly documented in the operative report, conceivably fits within the billing code description for HCPCS L8699 (1 unit) and the provider has included an invoice. Nevertheless, the submitted invoice is unclear as to the *price* for the item. The price indicated is the "package price." The quantity indicated is "1" but is not clear as to whether that amount refers to one package or one screw. If it refers to one package, it does not state how many screws are included in the package. Even taking the invoice at face value as supporting 1 screw — at most, the invoice would support a price of $213.20 + 10% ($21.32) add-on for a total of $234.52. However, the insurance carrier has paid more than this amount toward the implantable line item. Consequently, no additional reimbursement is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	June 9, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.